DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	445268	A. BUILDING: _____ B. WING _____	6/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTI	731 CASTLE HEIGHTS COURT LEBANON, TN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 202	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES

When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility policy review, and interview, the facility failed to complete a discharge summary and obtain a physician discharge summary for one resident (#55) of thirty admission records reviewed.

The findings included:

Resident #55 was admitted to the facility on May 9, 2014, with diagnoses including Multiple Fractures, Chronic Obstructive Pulmonary Disease, Diabetes, and Osteopenia. Further review revealed the resident was discharged from the facility on May 29, 2014.

Medical record review revealed no interdisciplinary discharge summary or physician's discharge summary.

Review of facility policy, Transfer & Discharge, Release/Revision date June 2007, revealed "...Complete the Interdisciplinary Discharge Summary...and obtain a Physician Discharge Summary..."

Interview with the Medical Records Director, on June 17, 2014, at 8:50 a.m., at the nurses station confirmed the facility failed to complete the Interdisciplinary Discharge Summary, and failed to obtain a Physician Discharge Summary.

Interview with the Director of Nursing, on June 17, 2014, at 9:50 a.m., at the nurses station confirmed the facility failed to follow the facility policy for Transfer & Discharge, failed to complete the Interdisciplinary Discharge Summary, and failed to obtain a Physician Discharge Summary.

The above isolated deficiencies pose no actual harm to the residents

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F 000	INITIAL COMMENTS During the Annual Recertification survey and investigation of complaint #33625 conducted on June 16-18, 2014, at Lebanon Health and Rehabilitation, no deficiencies were cited in relation to complaint #33625 under 42 CFR PART 483.13, Requirements for Long Term Care.	F 000	Disclaimer Submission of this response and plan of correction is not A legal admission that deficiency exists or that this statement of deficiencies was correctly cited, and is also not to be construed as an admission of interest against the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) ten days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote dignity during dining for one resident of nine residents observed in the main dining room. The findings included: Observation of the lunch dining in the main dining room on June 16, 2014, at 12:25 p.m., revealed Licensed Practical Nurse (LPN) #2, administered "pain medication" to resident #19 at the dining table during the lunch meal. Interview with LPN #2 following the administration of the medication, in the dining room, revealed the resident was given the medication "...because it was scheduled...(resident) doesn't normally come to the dining room, but I knew (resident) was hurting..." Further interview confirmed LPN #2 did not recognize medications given during	F 241	F241 SS=D 483.5 Dignity and Respect of Individuality Facility will promote care for residents in a manner that promotes or enhances their dignity and individuality. **Residents Affected/Potentially Affected by the Cited Deficient Practice:** Resident #19 has discharged.	7-31-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tracie Shelton — Administrator — 7-2-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 dining did not promote the resident's dignity.	F 241	**Identification of Other Residents Potentially Affected:** Residents residing in the facility that eat in the facility dining room. **Measures/Systemic Changes Implemented:** Social Services to give Education to licensed nurses on resident's dignity as it relates to administering medications in the facility dining room. Audit of facility dining room to be conducted weekly x 4 weeks then monthly x2 month to be completed by dietary manager. **Monitoring:** These findings will be presented in the Quality Assurance Committee monthly x3 months which is attended by the Administrator, Director of Nursing, Medical director, Social Services, Activity Director. 7-31-14	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F272 SS=D 483.2 Comprehensive Assessments Facility conducts initial and periodic comprehensive assessments of each resident's functional capacity. **Residents Affected/Potentially Affected by the Cited Deficient Practice** Resident #123 has discharged home from the facility. **Identification of Other Residents Potentially Affected:** Residents admitting to facility requiring MDS assessments with the diagnosis of Dementia.	

Joni Shelley Administrator 7-2-14

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F 272	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the Minimum Data Set was comprehensive and accurate for one resident (#123) of thirty-seven residents reviewed. The findings included: Resident #123 was admitted to the facility on May 12, 2014, with diagnoses including Pneumonia, Anemia, Depression, Anxiety and Dementia. Medical record review of the care plan dated May 23, 2014, revealed care planning for the diagnoses of Anxiety, Depression and Dementia and for medications for Anxiety, Depression and Dementia. Medical record review of the admission Minimum Data Set (MDS) dated May 23, 2014, revealed no assessment for Dementia. Interview with MDS Coordinator #1, on June 18, 2014, at 8:10 a.m., in the MDS office, confirmed the Dementia diagnosis was overlooked and was not coded correctly on the admission MDS.	F 272	**Measures/Systemic Changes Implemented:** 100% audit of residents for the diagnosis of Dementia by DON, Unit managers, and/or designee. Medical records to Audit 10% of new charts for Dementia diagnosis in computer system for weekly for 4 weeks then monthly for 2 months. **Monitoring:** These findings will be presented in the Quality Assurance Committee monthly x3 months which is attended by the Administrator, Director of Nursing, Medical director, Social Services, Activity Director. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved. 7-31-14	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	F309 SS=D 483.25 ADL care provided for dependent residents Facility strives to ensure that residents receive care and services to attain or maintain the highest practical physical, mental, and social well-being.	

T Sherfey Administrator 7-2-14

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F 309	Continued From page 3 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to follow facility policy for dialysis and facility to facility communication for one resident (#50) of thirty-seven residents reviewed. The findings included: Resident #50 was admitted to the facility on April 2, 2014, with diagnoses including Pleural Effusion, Schizophrenia, Chronic Kidney Disease, Diastolic Heart Failure, Hypertension, Congestive Heart Failure and Diabetes Mellitus. Medical record review of the care plan dated June 4, 2014, revealed "...receives Hemodialysis 3 times/week...AV (arteriovenous) fistula (L) (left) arm...fluid restrictions as ordered...colored arm band on the arm that has the shunt indicating 'No B/P (blood pressure) this arm' (was marked NA [not applicable])...Dialysis Communication Record is sent to the dialysis center with each appointment, and return of form is ensured after appointment is completed..." Review of the Dialysis Communication Records dated May 29, 2014, June 5, 2014, June 7, 2014, June 10, 2014, June 12, 2014, June 14, 2014, and June 17, 2014, revealed the records were incomplete, with missing documention including general information to be completed by the	F 309	**Residents Affected/Potentially Affected by the Cited Deficient Practice:** Resident #50 has been discharged. **Identification of Other Residents Potentially Affected:** Residents admitting to facility receiving dialysis. **Measures/Systemic Changes Implemented:** 100% audit completed on current dialysis residents for completed dialysis communication record, arm band, documentation of vital signs and time of departure and return to facility and for nursing documentation per dialysis policy. Addendum to policy was made to take vital signs twice within eight hours. DON, Unit manager or Designee to audit dialysis residents charts weekly for 4 weeks then monthly for 2 months. DON, unit manager or designee to educate licensed nurses on dialysis policy and procedures. **Monitoring :** These findings will be presented in the Quality Assurance Committee monthly x3 months which is attended by the Administrator, Director of Nursing, Medical director, Social Services, Activity Director. 7-31-14	

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F 309	Continued From page 4 facility, resident specific pre-dialysis information (completed by the facility), and information to be completed by the dialysis center. Medical record review of the Nursing Daily Skilled Summary dated May 29, 2014, revealed no documentation of the vital signs or time of return to the facility from dialysis. Medical record review of the Nursing Daily Skilled Summary dated June 5, 2014, revealed return time and thrill or bruit checks were not documented. Medical record review of the Nursing Daily Skilled Summary dated June 10, 2014, revealed "...out to dialysis..." and no time documented when the resident left the facility or returned to the facility. Medical record review of the Nursing Daily Skilled Summary dated June 14, 2014, revealed the vital signs section was incomplete. Medical record review of the Medication Record dated June 17, 2014, revealed no vital signs for the 11-7 (night) shift after returning from dialysis earlier in the day. Review of the facility policy Hemodialysis, Care of Residents revised June 2008, revealed "...place a colored armband that indicates 'no BP (blood pressure) this Arm' on the Resident's arm that has the shunt...A Dialysis Communication Record...is initiated and sent to the dialysis center each appointment; ensure it is received upon return...Check vital signs every shift for the 24 hours post-dialysis...Upon return from dialysis, the nurse will check for thrill* (*a thrill is checked by lightly placing fingertips over access site and	F 309		

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F 309	Continued From page 5 feeling for vibration) and bruit** (**a bruit is checked by placing a stethoscope over the shunt area and listening for blood flow) twice during the shift for which the resident returned...shunt care...ausculate (auscultate) & (and) palpate for presence of bruit or thrill...Dialysis (pre-post) method of transportation, medication given, and vital signs..." Observation of and interview with the resident on June 18, 2014, at 8:55 a.m., in the resident's room, revealed no arm band on either arm and the resident confirmed there was no arm band, "...I have to tell them not to take my blood pressure in this arm..." Further Interview revealed the staff had not felt or listened to the shunt when the resident returned from dialysis. Observation and interview with the Director of Nursing (DON) on June 18, 2014, at 9:00 a.m., in the resident's room, confirmed there was no arm band on either arm. Interview with Licensed Practical Nurse (LPN) #4 on June 18, 2014, at 9:40 a.m., in the DON's office, confirmed when a resident returned from dialysis the vital signs were to be checked, the shunt was to be checked, the return form was to be completed, and vital signs and shunt checks were to be documented on the Medication/Treatment record. Interview with the DON on June 18, 2014, at 9:50 a.m., in the DON's office, confirmed all dialysis communication forms were to be completed and had not been completed following the facility's policy.	F 309		
F 371	483.35(i) FOOD PROCURE,	F 371	F371 SS=F 483.35 Food procure, store/prepare/serve - sanitary	

GSherfey Administrator 7-2-14

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F 371 SS=F	Continued From page 6 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility dietary department failed to maintain a sanitary hood over four of four food production equipment; failed to maintain two of four food production equipment under the hood in a sanitary manner; failed to maintain the walk-in refrigerator floor in a sanitary manner; and failed to prevent contamination in the ice maker. The findings included: Observation and interview with the Chef and the Registered Dietitian, on June 17, 2014, at 8:30 a.m., in the dietary department, confirmed the following unsanitary conditions in the Dietary Department: 1. The entire interior surface of the hood and three of three light bulb glass covers over the convection oven, range top, steamer, and fryer was covered with dust; 2. The exterior dual doors of the convection oven had a sticky residue; 3. The right exterior side of the convection oven had an accumulation of debris;	F 371	Facility procures food from sources approved and stores, prepares ,distributes, and services food under sanitary conditions. **Residents Affected/Potentially Affected by the Cited Deficient Practice:** No specific residents were identified. **Identification of Other Residents Potentially Affected:** Residents have the potential to be affected by this practice **Measures/Systemic Changes Implemented:** Entire hood surface and light bulb glass covers over the convection oven, range top, steamer, and fryer was cleaned with all dust removed on 6-16-14. The exterior dual doors of the convection oven and the right exterior wall of the convection oven was cleaned of all debris and sticky residue on 6-16-14. The range top spill pan was cleaned free of rust and food debris removed from underneath on 6-16-14. The ice dispenser was cleaned and free from blackened residue on 6-16-14. The walk in refrigerator floor was resurfaced in rust area. Kitchen sanitary audit to be completed by registered dietician or dietary manager weekly for 4 weeks and then monthly for 2 months. Education to kitchen staff on proper cleaning of kitchen equipment given by Registered dietician and/or dietary manager. **Monitoring :** These findings will be presented in the Quality Assurance Committee monthly x3 months which is attended by the Administrator, Director of Nursing, Medical director, Social Services, Activity Director.. 7-31-14	

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F 371	Continued From page 7 4. The range top spill pan was rusted and had food debris under the foil; 5. The walk-in refrigerator floor was stained, worn off the floor surface with rust present. 6. The ice dispensing slot on the interior of the ice maker had a blackened residue present.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	F431 SS=E 483.60 Drug records, label/store drugs & biological Facility label and store drugs and biologicals in accordance with currently acceptable professional principles. **Residents Affected/Potentially Affected by the Cited Deficient Practice:** No specific residents were identified. **Identification of Other Residents Potentially Affected:** Residents receiving medications have the potential to be affected by this practice **Measures/Systemic Changes Implemented:** DON, unit manager or designee to in service all licensed nurses on proper labeling and storage of drugs and biologicals. 100 % audit of medication carts to be completed by the licensed nurse of proper labeling and storage of medications. Medication cart audit to be conducted by DON, unit manager or designee monthly for 3 months. **Monitoring :** These findings will be presented in the Quality Assurance Committee monthly x3 months which is attended by the Administrator, Director of Nursing, Medical director, Social Services, Activity Director. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved. 7-31-14	

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F 431	Continued From page 8 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview, the facility failed to appropriately store and label medications for two of three medication carts. The findings included: Review of facility policy, Storage and Expiration of Medications, Biologicals, Syringes and Needles, revised January 2013, revealed "...facility staff should record the date opened on the medication container...not retained longer than recommended by manufacturer or supplier guidelines...test reagents, germicides, disinfectants, and other household substances are stored separately from medications..." Observation on June 17, 2014, at 9:40 a.m., of the 200 medication cart, on the 200 hallway, with Licensed Practical Nurse (LPN) #1 revealed two bottles of opened, undated accucheck control solution. Continued observation revealed one bottle expired on February 2014. Interview with LPN #1, on June 17, 2014, at 9:40 a.m., on the 200 hallway, confirmed the two bottles of control solution were not labeled or dated and one bottle of control solution expired in February 2014. Observation on June 17, 2014, at 10:15 a.m., of the 100 medication cart, on the 100 hallway, with	F 431		

Administrator 7-2-14

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F 431	Continued From page 9 LPN #3 revealed one tube of opened antifungal cream. Continued observation revealed the medication was stored in the top right drawer with batteries, Band-Aids, two glucometers, air freshener, rubber bands, pens and tape. Interview with LPN #3, on June 17, 2014, at 10:15 a.m., on the 100 hallway, confirmed the medication was improperly stored in the medication cart.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	F441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility has an established Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **Residents Affected/Potentially Affected by the Cited Deficient Practice:** Resident # 194 and 18 have been discharged. **Identification of Other Residents Potentially Affected:** Residents residing in the facility have the potential to be affected by the practice. 7-31-14	

Administrator 7-2-14

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LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

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F 441	Continued From page 10 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to follow infection control isolation procedures for one resident (#194) of four residents observed in isolation and failed to wash or sanitize hands between resident contact for one resident (#18) of thirty-seven residents reviewed. The findings included: Resident #194 was admitted to the facility on June 5, 2014, with diagnoses including Delirium, Altered Mental Status, Encephalopathy, and Clostridium Difficile. Observation of the resident's room on June 16, 2014, at 10:00 a.m., revealed an isolation cart containing gloves, gowns, and masks were stored on the outside of the resident's room. Continued observation revealed the resident's door was closed and did not have a sign on the door alerting visitors or staff of the resident's isolation status. Further observation revealed a Certified Nurse Assistant (CNA #1) entered and exited the	F 441	**Measures/Systemic Changes Implemented:** Staff educated on infection control and isolation policy and procedures by Administrator and/or DON. Licensed nurses and CNA's have been re-educated on procedures for isolation residents and infection control by DON, Unit manager or designee. Department managers will do group rounds daily Monday - Friday monitoring infection control procedures. Audit of isolation residents for room signs and proper equipment weekly for 3 weeks then monthly for 2 months by Administrator and /or DON. Findings to be reported in the QA meeting. **Monitoring :** The Quality Assurance and Assessment Committee includes: the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved. 7-3-14	

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F 441	Continued From page 11 resident's room on two different occasions without donning gloves or gown. Continued observation revealed the CNA also did not wash or sanitize the hands before entering or leaving the resident's room. Medical record review of Admission Orders dated June 5, 2014, revealed, "...Isolation Precautions C. Diff (Clostridium Difficile)..." Review of facility policy Contact Precautions revealed, "...Gloves and Hand Hygiene...Hand hygiene should be completed prior to donning gloves...Gloves should be worn when entering the room and while providing care for the resident...Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately...Gowns...A gown should be donned prior to entering the room or resident's cubicle...Contact Precautions May Be Considered For (examples)...C. Clostridium difficile..." Interview with CNA #1 on June 16, 2014, at 10:00 a.m., in the 100 Hallway, confirmed the CNA entered and exited resident #196's room on two different occasions without donning gloves or gown. Continued interview confirmed the CNA was aware the resident was in isolation, however was not aware of what the resident was in isolation for. Further interview confirmed the CNA did not follow facility isolation precaution procedures. Interview with Licensed Practical Nurse (LPN) #6 on June 16, 2014, at 10:12 a.m., in the 100 Hallway, confirmed the resident was in isolation for Clostridium Difficile, and confirmed the CNA did not maintain infection control procedures.	F 441		

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F 441	Continued From page 12 Observation on June 16, 2014, at 12:55 p.m., in resident #18's room revealed Licensed Practical Nurse (LPN) #5 picked up an ice pack from the floor and placed it onto the left foot of resident #18. Further observation revealed LPN #5 exited resident #18's room without sanitizing or washing the hands. Continued observation revealed the LPN went to the nurses station and rubbed the face of another resident. Interview with LPN #5, at the nurses station, on June 16, 2014, at 1:05 p.m., confirmed the nurse did not sanitize or wash the hands after exiting resident #18's room and having direct contact with a separate resident.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, interview, and observation, the facility	F 514	F514 SS=E 483.75 Resident records complete /accurate/accessible Facility will maintain complete, accurate and accessible clinical records on each resident. **Residents Affected/Potentially Affected by the Cited Deficient Practice:** Resident #187 and 181 were assessed for weight loss. Resident #86 and #50 have been discharged. **Identification of Other Residents Potentially Affected:** Residents with impaired skin integrity and receiving supplements have the potential to be affect by this practice. **Measures/Systemic Changes Implemented:** 100% audit of residents with impaired skin integrity for weekly skin assessments and stage/size completed 7-31-14	

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F 514	Continued From page 13 failed to follow the facility policy to document the percent intake of a physician ordered supplement for three residents (#187, #181, #50) of thirty-seven residents reviewed; failed to follow the facility policy to ensure the monthly Physician Order Sheets were accurate for one resident (#181) of thirty-seven residents reviewed; and failed to follow the facility policy to document the admission and weekly pressure ulcer status for one resident (#86) of eight residents reviewed with pressure ulcers. The findings included: Resident #187 was admitted to the facility on May 30, 2014, with diagnoses including Hypertension, Insulin Dependent Diabetes Mellitus, History of Acute/Chronic Renal Failure, and Bilateral Heel Decubitus. Medical record review of the telephone order dated June 5, 2014, revealed "NSA (No Sugar Added) Med Pass (high calorie, high protein nutritional supplement) 4oz (four ounces) bid po (two times daily by mouth)." Medical record review of the June 2014, Medication Record revealed "NSA Med Pass 4 oz. po bid" was initialed by nursing for administration and no documentation of the percent intake. Review of the facility policy, Weight Management, revision date March 2010, revealed "...The percentage consumption of supplements...will be recorded on the Medication...Record..." Interview with the Director of Nursing, on June 18, 2014, at 1:40 p.m., at the nursing station, and	F 514	by RN wound nurse. Wound nurse to complete second skin assessment on each new admit. Educate all licensed nurses on skin management policy education to be done by DON and /or Unit manager. Educate licensed nurses to add supplement order with percentage to MAR when they take order and to send dietary communication form by DON and /or unit manager. Educate nurse managers completing monthly recap change over to double check MARs to physicians orders per policy by DON and/or Administrator. Audit of weekly skin assessments and documentation weekly for 4 weeks and then monthly for 2 months by DON, Unit Manager and/or designee. DON, unit manager or designee to Audit Supplement order to MAR and percentage documentation weekly for 4 weeks then monthly for 2 months. **Monitoring :** These findings will be presented in the Quality Assurance Committee. The Quality Assurance and Assessment Committee include the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved. 7-31-14	

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F 514	Continued From page 14 review of the June 2014, Medication Record, confirmed the facility failed to document the percent intake of the supplement on the Medication Record per the facility policy. Further interview confirmed the medical record was incomplete. Resident #181 was admitted to the facility on April 24, 2014, with diagnoses including Osteomyelitis, Hypertension, Pain, Orthopedic Aftercare, Depression, Spinal Stenosis, and Bilateral Below Knee Amputation. Observation on June 17, 2014, at 3:49 p.m., and June 18, 2014, at 7:50 a.m., in the resident's room, revealed the lunch tray and breakfast tray included two four ounce Mighty Shakes. Interview with resident #181 on June 18, 2014, at 7:50 a.m., in the resident's room, revealed the resident did not like the juice based Ensure the facility provided and had requested the Mighty Shakes. Medical record review of a telephone order dated April 28, 2014, revealed "Ensure (nutritional supplement) tid po w (three times daily by mouth with) each meal, 1 can w each meal." Medical record review of the April 2014, Medication Record revealed the "Ensure three times daily po with each meal (4/28/14) dietary provides" with no documentation of the percent intake. Medical record review of the May 2014, physician recapitulation (recap) orders revealed no order for the Ensure tid po with meals.	F 514		

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F 514	Continued From page 15 Medical record review of a telephone order dated May 27, 2014, revealed "D/C (discontinue) Ensure. Start 2 Mighty Shakes w each meal po (supplement)." Medical record review of the May 2014, Medication Record revealed "Ensure TID po w each meal (1 can/meal) dietary provides" and Mighty Shakes (2) w each meal-Dietary to provide." Further review revealed no documentation of the discontinuation of the Ensure as ordered May 27, 2014. Further review revealed no documentation of the percent intake of the Ensure or the Mighty Shakes. Medical record review of the June 2014, physician recap orders revealed "...Ensure three times daily by mouth with each meal. Document consumption..." Medical record review of the June 2014, Medication Record revealed "...Ensure three times daily by mouth with each meal. Document consumption..." Further review revealed no documentation of the percent intake of the supplement. Review of the facility document, Fluid Intake, dated April 28, 2014, through June 16, 2014, revealed a total of seven breakfast meals and nine lunch meals had documentation of fluid intake when nutritional supplements were ordered with each meal, but no percent of the nutritional supplement consumed. Review of the facility policy, Weight Management, revision date of March 2010, revealed "...The percentage consumption of supplements...will be recorded on the Medication...Record..."	F 514		

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F 514	Continued From page 16 Review of the facility policy, Monthly Changeover Process, revision date of August 2012, revealed "...Updated medication records (Physician Order Sheets (POS/Medication...Record...)...must be verified for accuracy and accepted by a licensed nurse before they can be used...A licensed nurse compares each line item on the newly printed form (POS/Medication...Record...) with the current month's Physician Order Sheet noting all new and discontinued orders...Review should include ALL active ancillary items...medication orders...Review and compare all current month's telephone orders to the POS, Medication...Record and document to ensure accuracy...A licensed nurse conducts a final check for accuracy...prior to placing them into use...Add all new orders from the current Telephone Orders that have occurred since the date of the first review..." Interview with the Director of Nursing and the Administrator, in the Administrator's office, on June 18, 2014, at 9:30 a.m., confirmed the facility failed to document supplement intake on the Medication Record per facility policy. Further interview confirmed the facility failed to consistently document fluid intake. Further interview confirmed the facility failed to ensure the Physician Orders were accurate to reflect telephone orders after the initial POS review per facility policy. Further interview confirmed the medical record was not complete and not accurate. Resident #50 was admitted to the facility on April 2, 2014, with diagnoses that included, Pleural Effusion, Schizophrenia, Chronic Kidney Disease, Diastolic Heart Failure, Hypertension, Congestive	F 514		

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F 514	Continued From page 17 Heart Failure and Diabetes Mellitus. Medical record review of the Medication Record for June 2014, revealed "...Nepro (nutritional supplement for renal condition) 1 can po (by mouth) BID (twice a day) /c (with) breakfast and dinner tray...served on meal tray..." Medical record review revealed no documentation regarding the percentage of intake of the Nepro. Observation of the breakfast tray on June 17, 2014, at 8:15 a.m., revealed an unopened can of Nepro on the breakfast tray. The resident did not open the Nepro at the time of the observation. Interview with the Unit Manager Registered Nurse (RN) #1 on June 17, 2014, at 10:15 a.m., in the 300 hallway at the medication cart, confirmed the Nepro percentage consumed was not documented. Resident #86 was admitted to the facility on February 4, 2014, with diagnoses including Pressure Wounds, Congestive Heart Failure, Alzheimer's Disease, and History of Seizures. Further review revealed the resident was discharged from the facility for a pre-scheduled wound debridment on February 27, 2014. Medical record review of the Weekly Pressure Ulcer Report revealed the Date of Onset was February 4, 2014; the site was coccyx, stage 3 and 6.0 centimeters (cm) x (by) 5.4 cm x 3.0 cm; and the Left hip with no documentation of stage or size. Further review revealed weekly assessments on both of the wounds were documented, with a decrease in size noted, and the last weekly assessment documented was	F 514		

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F 514	Continued From page 18 dated February 18, 2014 (nine days prior to the discharge). Review of the facility policy, Skin Management, revision date of August 2012, revealed "...Newly admitted residents...Upon admission, all residents are assessed for skin integrity by completing a head to toe physical assessment of skin condition...residents admitted with skin impairment will have...the following forms completed and placed with the resident's Treatment record: Pressure Ulcer: Weekly Pressure Ulcer Report...Wounds are tracked...and are assessed and documented on the Weekly Pressure Ulcer Report...Skin Assessments...Pressure ulcers are measured and staged weekly..." Interview with Registered Nurse #1, on June 17, 2014, at 12:38 p.m., in the Director of Nursing office, confirmed RN #1 was the Wound Nurse assessing resident #86 in February 2014. Further interview confirmed there was no documentation of the stage or size of the Left Hip wound on admission on February 4, 2014. Further interview confirmed the weekly assessment had not been documented prior to the discharge on February 27, 2014. Interview with the Administrator, on June 28, 2014, at 9:20 a.m., in the Administrator's office, confirmed the facility failed to document the admission pressure wound assessment for the left hip and failed to document a weekly assessment per facility policy. Further interview confirmed the record was not complete and not accurate.	F 514		

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